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The Honorable William E. Kennard, Chairman
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FEDERAL COMMUNICATIONS COMMISSION

Dear Mr. Kennard:

After much consensus building and work, we in Alabama have established the Rural Medical Scholars Program to enroll 10 students per year into medical school and prepare them for rural practice. This major accomplishment will pay dividends in rural health care when these students locate and remain in rural practice.

These young physicians must find a rural community responsive to their professional needs and rural values if they are to succeed in re-establishing rural community roots. For this reason, it is imperative that rural voices inform the Federal Communications Commission's policies that impact rural health care. I strongly urge you to assist us in Alabama to secure these doctors in rural communities by composing the Rural Health Care Advisory Committee completely of rural telehealth and health care experts. Urban experience and urban values are not effective to influence the choices of these students to develop rural practice

I would be pleased to recommend potential advisors, if that were helpful.

Sincerely yours,

John R. Wheat, M.D.
Director, Rural Medical Scholars Program

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# Strategy to Overcome Urban Undertow, An Obstacle to Rural Health Development

John R. Wheat, MD, MPH

**ABSTRACT.** Urban undertow occurs when resources for rural communities are drawn into urban institutions, contributing to urban development and paradoxically undermining rural growth. Eroding rural health care services is a prime example. Central to this problem is health care policy promoting costly medical science and technology without also advancing the infrastructure for basic rural medical care.

What is needed in order to preserve and restore rural quality of life is an explicit policy to (a) recognize the presence and legitimacy of rural institutions to be recipients of funding and (b) create a comprehensive strategy to channel resources into effective rural development. Recruiting and preparing rural students for rural health professions would be an important part of the strategy.

**KEYWORDS.** Rural development, rural health, rural policy, urban undertow

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## INTRODUCTION

Rural development requires a strategy to halt a continuous decline in resources that are integral to a community's quality of life.[1,2] These resources include a broad and interwoven array of services, publicly and privately delivered, such as schools, libraries, sanitation, clean water and health care.[2] Nowhere is the erosion of rural quality of life so evident as in health care, largely due to marketplace dynamics that frustrate efforts to create medical safety nets for rural people. When an older physician retires or a younger one moves to a city or a town offering a more lucrative, less exhausting practice or a more attractive environment for raising a family, the community must quickly recruit a new doctor or the central component of the area's health-care system will collapse. Throughout the country, rural communities are struggling to maintain their local physician-centered health-care system if they are fortunate enough to have a physician. If not, they are involved in the much harder task of attracting a doctor, or have given up and accepted their medical disfranchisement as inevitable. Thirty thousand dollars per year is the figure given by some rural hospital administrators as the price required to hire recruiters to simply locate a physician who will come to a rural community.

Self-determination and community involvement are vital to the health of any community.[2,3] Therefore, strategies for rural community development should begin with strong local leadership and voice, and should build on commitment to emphasize local potential. Analysis of the failure of one rural health care system after another reveals the critical mistake of entrusting too much control to distant entities, who may have little concern for local credibility and who may have incentive to overinvolve their distant affiliations in the plans for the community. As examples, hospitals in Livingston and Butler, (Alabama) closed when distant owners found them to be unprofitable. In the case of Butler, local physicians withdrew from practice in the hospital when patients were preferentially shunted by the administration to a larger urban hospital for procedures (CAT scan, obstetrics) that could have been provided locally. This contrasts with a hospital in Carrollton, Alabama, where a distant owner found the hospital unprofitable and withdrew. Local physicians bought the hospital and convinced the county to support

it with a county tax. The hospital now thrives under local ownership and management.

## *URBAN UNDERTOW*

Urban undertow is a condition in which resources of rural communities, or resources that are designed to meet rural community needs, are drawn into urban institutions. Consequently, the resources contribute to urban development and may, paradoxically, undermine rural growth by making rural communities more dependent on urban centers. Urban undertow is closely related to science and technology which are key ingredients to economic advancement. Urban areas have concentrated scientific and technological expertise in institutions of education, industry, government and service. This expertise combines with the electoral clout of dense populations to help urban institutions compete effectively for funds designated to meet public needs. Kohls[4] touches on this when discussing how university departments may redefine a fundable idea, e.g., rural development, to support what the departments are already doing. Thus, urban institutions capture public funds and provide structure and opportunity for the use of their science and technology.

Control of funds brings to urban institutions additional potential to influence use of science and technology through the process of public policy. Institutions with large budgets meet with receptive ears around policy tables where public officials hope to satisfy constituencies most economically. If these officials are able to direct institutional funds toward constituents' needs, then the public receives a desired product at no additional taxes. For example, a medical school whose budget is redirected to produce more small town physicians will gain public favor for the medical school and the policy maker.

However, individuals representing institutions will most readily recognize public needs that match their institutional interests and can be addressed through methods familiar to them. Thus, urban institutions can, and do, focus public resources on problems already within their spheres of influence and expertise. Take the medical school example: the school may further redirect the policy makers'

interest from rural physicians to generalist physicians, who are likely to have non-rural inclinations. As a consequence, alterations in the selection and training of physicians that would most effectively meet the need for more rural doctors would be forestalled.

Though America's great urban medical centers work Biblical feats hourly, clearly all that biomedical firepower is not essential to the delivery of sound primary health care in a community. In fact, in case after case it has been the lack of sound primary health care that has sent anxious and bewildered patients, both rural and urban, into the great tertiary care hospitals for expensive diagnostic and surgical procedures. If the massive, modern medical center's technology is not essential to basic health care, what other forces are driving the continuing urbanization of medical delivery?

## *LACK OF A COHESIVE SYSTEM*

The core of the problem is the failure of policy makers to distinguish between medical issues that can be best attended to in the tertiary-care, urban medical setting and those best dealt with in the patients' communities, in the context of their families, their jobs, their associations–in short, their lives. The burst of science during World War II and the Post War years made the development of the modern medical center inevitable, and it has been one of the greatest blessings the American people have known. But government and philanthropy have by and large placed all their eggs in that one basket when it comes to health-care policy. While pushing very costly medical science, policy makers have failed to make concurrent efforts to develop and strengthen the infrastructure for a cohesive system of rural and small-town medical care. As a result, rural communities and small towns have a scarcity of the expertise and technology needed for primary medical care. The failure of predominant government and philanthropic funding policy to recognize the necessity of a fundamental equilibrium between the tertiary care medical system and the community/rural medical system means there is insufficient advocacy of community/rural needs, and insufficient venue in which such advocacy can take place. Consequently, in the competition for health-care resources, there is a chronic decrease in resources for rural development as urban areas

control a larger share. This necessarily means diminished opportunity for health-related jobs to which rural people would aspire both to provide careers and to remain in their communities.

## *EFFECT ON RURAL YOUTH*

The concurrent decline in rural opportunity and increase in the biomedical job market causes an accelerated flow of technological talent into cities. The phenomenon has a particularly cruel and ironic twist. Rural youth attracted to urban jobs find themselves working in institutions with priorities that, by design, deny them opportunity to advance the potential of their home communities. In the case of health care, rural folk whose youth work in the city must be willing and able, financially and psychologically, to go to the city to obtain the services of their own young people, as well as share their lives in the city.

Over time, individuals who come to the city from rural beginnings may increasingly identify with their urban institutions and begin to fight the institutions' battles, even when there is conflict with rural community development needs. The identification process is accelerated by pressures of peers in the institution who are not from rural areas and do not comprehend rural values or issues. Consequently, the children of the countryside turn into science-based experts committed, often unwittingly, to urban development above all else. The livelihood and professional and social niches provided by these institutions compel individuals to assume roles that may require an apathetic, if not adversarial, stance toward rural communities. This transition of rural young people, such as medical students, to an urban perspective does not bode well for small, rural communities struggling in a losing battle for developmental resources required for community survival. This loss of the community's most valuable resource, its children, is the penultimate step in urban undertow.

## *QUALITY OF LIFE*

The "so what?" behind this disparity in access to public resources is that the quality of life in our rural communities is in rapid

decline. No longer can a farmer, school teacher, lumberman, miner, paper mill worker, or other person residing in a rural town or community expect to obtain basic medical and educational services on a par with his urban counterpart. People such as these are vital to securing our future supplies of food, clothing, minerals, lumber, and related products. Despite ambivalence to rural and small town life, it remains crucial to maintain a value system central to the American identity. What is the incentive for a new generation to remain in the countryside, if they must live a second class existence? The decline in rural opportunity and economic potential will bring about further decay in fundamental community services and jeopardize those rural resources that the entire public, rural and urban, hold dear.

## *STRATEGY*

The solutions to rural decline may be many, and they are certainly complex. However, any solution must include provisions to enhance rural community competitiveness for public resources and rural voice in public policy. That will require an explicit recognition that, though sparse rural populations can be outvoted by city folks any day, a strong, dynamic rural life is part of the diversity that must be maintained for the good of the whole. Only in this way will rural communities begin to accrue opportunities that make for meaningful livelihoods. Without it, urban institutions may mistake the intent of funding for rural public purposes and develop further urban expansions *in the name of rural programs*, continuing to maintain the cycle that undermines rural communities.

## *FOUR COMPONENTS*

A primary element in the strategy to slow rural decline and enhance competitiveness for public funds is to maintain *the presence of institutions* eligible to receive them. These institutions might include traditional ones such as schools, churches, healthcare facilities, and local governments, or not-for-profit organiza-

tions for special functions. For rural development to occur, these rural institutions should use every opportunity to invest locally. The very soul of these institutions–the leadership and the rank and file–must be committed to rural advancement to avoid an urban undertow.

Another necessary component will be the commitment of resource providers, whether governmental or private, to recognize the *legitimacy of local rural organizations* in contrast to the inefficiency of urban organizations in using resources intended for rural advancements. Those who supply resources may require that a particular expertise be included in a rural organization's activities. However, the resource agency should continually recognize the necessity of local control and, thus, honor the community organization's right to be a full partner in deciding how to obtain expertise, as long as the final outcome satisfies the resource provider.

The third necessary element is a *comprehensive plan* to capture resources, convert them to programs that build rural potential for economic development, and develop a positive cycle of rural community enhancement. Continuing local leadership is required to guide the program and to guide partners who support the strategy's purpose.

The fourth component is *educational*. Preparing health care professionals for rural practice is an education-based strategy that recognizes science and technology as the keystone of economic development. The goal would be to link education at all levels, elementary through professional, to the rural community context with its inherent values. The strategy will require resources to enhance the capabilities of rural educational institutions and to adapt other rural and urban organizations to support various programs. The programs in and of themselves will provide some new rural opportunities, but the eventual outcomes will be an increase in rural, science-based expertise and quality of rural community life that attracts people and develops additional opportunities.

## *CONCLUSION*

Access to quality rural health care is increasingly recognized as basic to one's choice to live and work and raise one's family in a

rural setting. Rural physicians contribute to the quality of life not only through health care, but through their economic development potential for the community.[5] There are well developed and tested methods for identifying and educating individuals who will become rural physicians.[6,7,8,9,10] However, these methods require changes in allocations of resources and in traditional medical education. Proponents of such changes would do well to recognize, as Kohls[4] suggests, the propensity for current academic structures to redefine the thrust of funding for change rather than to make changes in the academic endeavor.

This diversion of funds intended for rural developments into the support of urban institutions is the sine qua non of urban undertow. Urban undertow is so pervasive that special strategies are required to counteract its effects. Local community control and leadership are key to those strategies in order to maintain rural values and enhance rural development.

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